Coates' Canons Blog: Consolidated Human Services Agencies and the NC Local Health Department Accreditation Program

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UPDATE FEBRUARY 2013: The accreditation rules were amended to change the method by which the Accreditation Board determines whether a department has satisfied the required benchmarks.See 10A N.C.A.C. 48B .0103. This change had been proposed when this post was originally published, and is described under the question, "What must an agency do to be accredited?" The amendments became effective February 1, 2013.

Recent legislation **[S.L. 2012-126 (H 438)]** authorized any North Carolina county with a county-manager form of government to create a consolidated human services agency (CHSA). Under newly amended **G.S. 153A-77**, a board of county commissioners may create a CHSA with the authority to carry out the functions of any combination of county agencies, boards, or commissions that provide human services. Although the law does not require that a CHSA include any particular local agencies, it does specifically mention public health and social services departments as agencies that may be included. In September, my colleague Aimee Wall wrote **this post** about three North Carolina counties that have made changes to local human services as a result of H 438, including two that had formed CHSAs combining public health and social services. Since then, at least two more counties have created CHSAs that incorporate the local health department and several other counties are considering doing so.

In North Carolina, local health departments are required by law to obtain and maintain accreditation. If the local health department becomes part of a CHSA, then the CHSA acquires the duty to obtain and maintain accreditation. How is this so, and what does it mean for counties that create a CHSA incorporating public health?

Why must a CHSA be accredited as a local health department?

When a county creates a CHSA that includes public health, the consolidated agency acquires "the responsibility to carry out the duties of a local health department." **G.S. 130A-43(a)**. One of the duties of a local health department is to obtain and maintain accreditation through the North Carolina Local Health Department Accreditation program. **G.S. 130A-34.1(f)**. Effective July 1, 2014, an agency providing local public health services in North Carolina must be accredited in order to continue to receive state and federal public health funding. **G.S. 130A-34.4**.

What must an agency do to be accredited?

Local health departments or CHSAs that provide local public health services must satisfy accreditation standards established by the North Carolina Commission for Public Health, the statewide rulemaking body for public health. The standards have been adopted as rules and are published in the **North Carolina Administrative Code**, Title 10A, Chapter 48.

The accreditation standards establish 41 benchmarks addressing the agency's core functions and essential services, facilities and administrative services, and governance. Each benchmark has a list of activities associated with it. To satisfy a benchmark, the agency must complete all of the activities associated with the benchmark. For example, **Benchmark 36** requires local board of health members to be trained regarding their service on the board. To satisfy this benchmark, a local agency must complete three activities: (1) provide board of health members with an up-to-date handbook, (2) assure that new board members receive training and reference materials within their first year of service on the board, and (3) assure that board members receive ongoing training in the authorities and responsibilities of boards of health.

The current rules require an agency to satisfy at least 33 of the 41 benchmarks, including a minimum of 22 benchmarks related to agency core functions and essential services, three related to facilities and administrative services, and six related to governance. The two additional required benchmarks may come from any of those categories. The Commission for Public Health recently approved a change to the rules that will focus on activities rather than benchmarks. Under the rule change, an agency will be required to satisfy at least 83 of the 103 activities related to agency core functions and essential services, at least 24 of the 27 activities related to facilities and administrative services, and at least 25 of the 28 activities related to governance. The rule change is not yet final, as it is awaiting consideration by the Rules Review Commission. ***[Update: The rule change became effective February 1, 2013. Agencies accredited after that date must satisfy the number of activities for each category described in this paragraph.]***

How does this apply to an agency that does not have a "board of health"? For example, when a CHSA provides public health services, it does not have a board of health – it either has a consolidated human services board or is directly governed by the county commissioners.

It is correct that a CHSA is governed by something that is not called a "board of health." A CHSA may be governed by an appointed consolidated human services board, or it may be governed directly by the county commissioners under a part of the new legislation that authorized commissioners to assume direct control of certain local boards. **G.S. 153A-77(a)**. In either case, the CHSA's governing board becomes the "board of health" for purposes of the accreditation requirements, as well as for other laws that assign authority or responsibilities to a local board of health.

Here's how it works: If a consolidated human services agency includes public health, by law the board that governs the agency acquires the responsibilities, powers and duties of a local board of health, except direct appointment of the local health director. **G.S. 153A-77(d)**; see also **130A-43(b)**. One of the duties the governing board thus acquires is the duty to satisfy accreditation standards that specify activities for the local board of health. If a CHSA has an appointed consolidated human services board, the appointed board is responsible for satisfying the accreditation requirements that require action by the local board of health. If a CHSA is governed directly by the county commissioners, the commissioners are responsible for satisfying those requirements.

Which local health department accreditation requirements affect the agency governing board?

There are references to the board throughout the accreditation standards, but most of the activities that the governing board is directly responsible for are contained in the accreditation standards on governance — benchmarks 34 through 41 (10A N.C.A.C. 48B.1301 – .1308). Those benchmarks address local public health rule-making; adjudications related to local public health rules and fines; board of health training; the development, implementation and evaluation of local health services and programs to protect and promote public health; the establishment of public health goals and objectives; assurance of resources to implement public health essential services; advocating in the community on behalf of public health; and promoting public health partnerships.

If a CHSA is governed directly by the county commissioners, may the commissioners take on some of the powers and duties of the governing board, but give others—including the accreditation responsibilities—to an advisory committee?

First, let's talk about the creation of a health advisory committee, since that is something that the new legislation addresses. If a CHSA that includes public health is governed directly by the county commissioners, the commissioners must appoint an advisory committee that includes the same membership as a county board of health: a physician, a dentist, an optometrist, a veterinarian, a registered nurse, a pharmacist, a county commissioner, a professional engineer, and three representatives of the general public. G.S. 153A-77(a); **130A-35**. The new law does not describe the advisory committee's role or give it any particular powers and duties, but it seems clear that its purpose is to advise the commissioners when they carry out duties that would otherwise be performed by a local board of health.

Now, to the question of whether the board of county commissioners may divide the CHSA governing board responsibilities, assuming some to itself but assigning others to the advisory committee: When a board of county commissioners wishes to assume the duties of a CHSA board, it does so by adopting a resolution "assuming and conferring upon the board of county commissioners *all* powers, responsibilities and duties" of the board. G.S. 153A-77(a) (emphasis added). This statutory language does not appear to allow the commissioners to assume only some of a board's

powers and duties – it seems to be an all-or-nothing proposition. Further, **G.S. 153A-76**—the state statute that generally permits county commissioners to organize county government—specifically prohibits assigning elsewhere "a function or duty assigned by law to a particular office, position, department, *board*, commission, or agency" (emphasis added). As I explained previously, when a CHSA is created its governing board acquires the powers and duties of a local board of health, including those that pertain to the agency's accreditation. So, when the board of county commissioners is the CHSA's governing board, it acquires those duties.

Could the commissioners assume all the responsibilities, powers and duties of a CHSA board but then delegate some of them to the advisory committee?

This is a slightly different question, as assumption of duties followed by delegation is a bit different from dividing the duties between entities in the first place. However, I think delegation of duties assigned by law to the governing board—as the accreditation duties are—still runs afoul of G.S. 153A-76(3) and its prohibition on reassigning such duties. Further, several of the accreditation benchmarks and activities require the exercise of a board of health's statutory duties, such as policy-making or rule-making (**G.S. 130A-39**), or adjudication (**G.S. 130A-24**). Nothing in the board of health statutes permits the delegation of those powers or duties to another person or entity. (In contrast, boards of social services are expressly authorized to **delegate certain of their duties to the local director of social services**.)

In practice, I believe the commissioners could use the advisory committee to inform their work in satisfying accreditation standards. That would certainly seem to be consistent with the rationale for having an advisory committee in the first place. But ultimate responsibility for satisfying the accreditation standards still appears to lie with the commissioners.

Links

- reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2048%20-%20local%20health%20department%20accreditation/subchapter%20b/10a%20ncac%2048b%20.0103.pdf
- www.ncleg.net/Sessions/2011/Bills/House/PDF/H438v5.pdf
- www.ncleg.net/gascripts/statutes/statutelookup.pl?statute=153A-77
- canons.sog.unc.edu/?p=6853
- www.ncleg.net/gascripts/statutes/statutelookup.pl?statute=130A-43
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- www.ncleg.net/gascripts/statutes/statutelookup.pl?statute=130A-35
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